RI Department of Health
PO Box 1615
Providence, RI 02901-1615
www.healthri.org

RI Department of Health

Application and Instructions for:

Massage Therapy Establishment

_____

Applicant Name (Name of Business)

_____

Previous Business Name & License Number (If Any) at this address

OFFICE USE ONLY

	Initials	Date
Risk Type		
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.

- Registration forms must be either typed or legibly printed using a ball point pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.

- Attach check/money order to the front of this application and mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. Please do not hand deliver this form to the Department of Health. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Massage Therapy Establishment $125.00

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.

- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Please complete section(s) below.

NOTE: A licensed Massage Therapist is required to operate a Massage Therapy Establishment.

Licensed Massage Therapist: Please indicate the license number of the designated Massage Therapist(s) who provides service at this location. (Owner/manager or designee).	Name: _____ License Number: _____

State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: ( ) _____
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website).**	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. (P**ublished on HEALTH website)**	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____
Ownership Type : Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership ☐ Partner
Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	**LIST ONE ONLY - DO NOT SEND ATTACHMENTS** Name: _____ DBA (Doing Business As): _____

Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City, State, Zipcode _____ Phone: _____ Fax: _____ Email Address: _____
Water Supply:	Does this establishment receive all or a portion of its water supply from an on-site well? ☐ Yes ☐ No
Sewage System:	Is this establishment serviced by a private sewage system (e.g. septic system)? ☐ Yes ☐ No
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **Signature of Authorized Person** — **Date of Signature (MM/DD/YY)** **Printed Name of Authorized Person** **Title of Authorized Person**